



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: KINDRED HOSPITAL OF DALLAS 9525 GREENVILLE AVENUE DALLAS TX 75243	MFDR Tracking #: M4-04-3348-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Carrier's Austin Representative Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Services rendered of like kind are allowed by other payors at a reasonable and customary rate well above the rate of 7% applied by Texas Mutual. For this procedure specifically, Amerisure representing Composite Panel Technology Group Workers' Compensation program's allowable @ 85%, CorVel Corp. representing Luby's Cafeteria Group. Workers' Compensation program's allowable @ 30% and Segwich Managed Care Intracopr representing International Paper Company Group Workers' Compensation program's allowable @ 60% Please find documentation attached to validate this statement." "In discussion, I respectfully submit for your consideration, that the payor's application of Medicare ASC rates plus 20% resulting in payment for this procedure at a rate of 7% is in contradiction to the following: TWCC ACT CHAPTER 413. MEDICAL REVIEW SUBCHAPETER B MEDICAL SERVICES AND FEES 413.011 REIMBURSEMENT POLICIES AND GUIDELINES; TREATMENT GUIDELINES AND PROTOCOLS b)."

Amount in Dispute: \$6574.44

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is this carrier's position that a) the requester failed to produce any credible evidence that its billing for the disputed procedure is fair and reasonable; b) the requester failed to prove its usual and customary fees for the service in dispute is fair and reasonable are consistent with Section 413.011(b); c) this carrier's payment is consistent with fair and reasonable criteria established in Section 413.011(b) of the Texas Labor Code; and d) Medicare fair and reasonable reimbursement for similar or same services is below this carrier's."

Response Submitted by: Deborah Bailey, 221 West 6th Street, Suite 300 Austin, TX 78749

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
2/19/2003	M, JX, T2, D, YD, O, YO	Outpatient Surgery	\$6574.44	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on November 10, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on November 17, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code(s):

- M-No MAR.
 - JX-Fair and reasonable reimbursement for the entire bill is mad. [sic]
 - T2-Code description not listed.
 - D-Duplicate bill.
 - YD-Duplicate appeal. An appeal of the original audit decision was previously performed for these services. If you disagree with the original appeal decision, you may request medical dispute resolution through the Texas Workers' Compensation Commission.
 - O-Denial after reconsideration.
 - YO-Reimbursement was reduced or denied after reconsideration of treatment/service billed.
2. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
 3. This dispute relates to services with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
 4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
 5. Division rule at 28 TAC §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(B).
 6. Division rule at 28 TAC §133.307(g)(3)(E), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to "Prior to submission, any documentation that contains confidential information regarding a person other than the injured employee for that claim or a party in the dispute must be redacted by the party submitting the documentation, to protect the confidential information and the privacy of the individual. Un-redacted information or evidence shall not be considered in resolving the medical fee dispute." Review of the documentation submitted by the requestor finds that the requestor has submitted unredacted confidential information regarding a person other than the injured employee. Therefore, the requestor has failed to complete the required sections of the request in the form, format, and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(g)(3)(E).
 7. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
 8. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
 - The requestor's position statement states that "Services rendered of like kind are allowed by other payors at a reasonable and customary rate well above the rate of 7% applied by Texas Mutual. For this procedure specifically, Amerisure representing Composite Panel Technology Group Workers' Compensation program's allowable @ 85%, CorVel Corp. representing Luby's Cafeteria Group. Workers' Compensation program's allowable @ 30% and Segwich Managed Care Intracopr representing International Paper Company Group Workers' Compensation program's allowable @ 60% Please find documentation attached to validate this statement." "In discussion, I respectfully submit for your consideration, that the payor's application of Medicare ASC rates plus 20% resulting in payment for this procedure at a rate of 7% is in contradiction to the following: TWCC ACT CHAPTER 413. MEDICAL REVIEW SUBCHAPETER B MEDICAL SERVICES AND FEES 413.011 REIMBURSEMENT POLICIES AND GUIDELINES; TREATMENT GUIDELINES AND PROTOCOLS b)."

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor does not discuss or explain how additional payment of \$6574.44 would result in a fair and reasonable reimbursement.
- The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”
- In support of the requested reimbursement, the requestor submitted redacted and un-redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. Un-redacted information or evidence was not considered in resolving this medical fee dispute. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

9. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(B), §133.307(g)(3)(C), §133.307(g)(3)(D) and §133.307(g)(3)(E). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
 28 Texas Administrative Code §133.307, §134.1
 Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

5/10/2011

 Authorized Signature

 Medical Fee Dispute Resolution Officer

 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.